World Health Organization

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By: Health Services Delivery Programme

Division of Health Systems and Public Health

ROADMAP

Strengthening people-centred health systems in the WHO European Region

A Framework for Action towards Coordinated/Integrated Health Services Delivery (CIHSD)

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ABSTRACT

The proposed Framework for Action towards Coordinated/Integrated Health Services Delivery (CIHSD) draws on the Regional Director's (RD) vision and that of Health 2020 for strengthening health system performance through innovative approaches to modernize and transform the delivery of services in order to better respond to the health challenges of the 21st century. The purpose of this document is to provide an overview of the core phases and respective processes in developing a Framework for Action towards CIHSD. The Roadmap at hand is intended as a planning tool to guide this process, generating discussion and facilitating opportunities for pragmatic collaborations and consultations throughout the phases and processes defined. In giving structure to the technical work on CIHSD at the WHO Regional Office for Europe, the Roadmap aims also to ensure the improved coherence of ongoing and future products and to maximize the relevance of this work for Member States. This Roadmap document is divided into five sections, giving a narrative to the following: (1) a brief overview of the coordination/integration of health services delivery looking to key definitions, concepts, and evidence available in the literature; (2) the context of the European Region to which this work plan intends to respond including the experiences of Member States and related work of the Regional Office to-date; (3) the envisioned Framework for Action towards CIHSD – its objectives, technical framework and expected outcomes and impact; (4) the specific phases and processes for its development; and (5) a description of key partnerships necessary to ensure this process is participatory and guided by continuous consultations with Member States, across in-house divisions and with external experts.

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PREFACE

[Aims of Health 2020] *"To significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality"* (WHO Regional Office for Europe, 2012a).

Building on the vision of current and earlier global commitments[1], a World Health Organization (WHO) global strategy to towards high quality, people-centred and integrated care is currently being developed. With the aim of universal health coverage – a continued priority expressed most recently just this past May (2013) at the 66th World Health Assembly (see resolution WHA66.23) – the strategy calls for strong health systems to provide a range of quality, affordable services and at all levels and sites of care. Taking an evidence-informed, forward-looking approach, the strategy intends ultimately to support WHO, it's Regional Offices and it's Member States in tackling persisting health system barriers that continue to limit the availability of services and lack of people-centredness in the delivery of care.

In the WHO European Region, efforts at present for health system strengthening (HSS) are guided by the new European health policy, Health 2020, committing Member States to achieve the Region's health potential by year 2020 (WHO Regional Office for Europe 2012a). The umbrella policy framework places great importance on HSS as one of its four priority areas, recognizing the unique responsibility of health systems to deliver services that improve, maintain or restore the health of individuals and their communities. This priority importantly recalls the commitments set out in the 2008 Tallinn Charter – a milestone for the European Region, marking the importance that Member States place on improving the performance of their health systems and the direct relation between this and secured gains in population health and wealth (RC/EURO 2008).

Highlighting the importance of people-centred and integrated care, the European Union has recently launched initiatives aiming in the same direction. The European Innovation Partnership on Active and Healthy Ageing (EIP AHA, European Commission 2012), and the health research priorities defined in the FP7 research programme (European Commission 2005), all work towards transformed and strengthened health systems in line with the Europe 2020 strategy (European Commission 2010). Research and innovation in this area will further be strengthened by the new framework programme Horizon 2020 (European Commission 2011). As has the World Health Organisation, so has the European Union recognized the need for a pro-active approach to help its member states strengthen their health systems, and enable its citizens to lead healthy and self-determined lives in line with the life-course approach. Hence, Europe 2020 and Health 2020 will logically complement each other, while adapting to the needs of its respective member states.

Central to improving the performance of health systems are transformations in how services are delivered. This is recognized in the operational approach to HSS of the Division of Health Systems and Public Health (DSP), ensuring the removal of health system bottlenecks that effect

[1] Recalling the Declaration of Alma-Ata (1978), resolutions such as WHA54.13, WHA56.6 and WHA62.12 and summits on health system strengthening such as the International Conference dedicated to the 30th Anniversary of the Alma-Ata Declaration on primary health care (Almaty, 2008).

coverage of core services in a given priority health area (WHO Regional Office for Europe 2012b). Moreover, transforming the delivery of services is a fundamental component in a number of strategies across technical Divisions at the Regional Office[2]. Importantly, a core tenet of these efforts is strengthening the coordination/integration of care such that the provision of health services is organized according to the needs and expectations of the individual, overtime and across the full continuum of care.

It is in response to needed transformations in the delivery services and in the context of the guiding commitments described above that the Framework for Action towards Coordinated/Integrated Health Services Delivery (CIHSD) has been conceived. The Roadmap document at hand is envisioned as a planning tool to communicate the processes to achieving the Framework for Action towards CIHSD by 2016. In the sections to follow, the concepts and context surrounding this work plan are further described, with priority then given to defining the phases, processes and products as well as key partnerships and a timeline for these efforts from the present until the final presentation of this work for Member State endorsement.

[2] This includes the WHO European Regional Action Plan to Strengthen Public Health Capacities and Services (RC62, Malta); the WHO European NCD Action Plan (RC61, Baku); the Regional Action Plan to Prevent and Combat MDR-TB and HIV (RC61, Baku); and the Strategy and Action Plan for Healthy Ageing in Europe 2012 – 2020

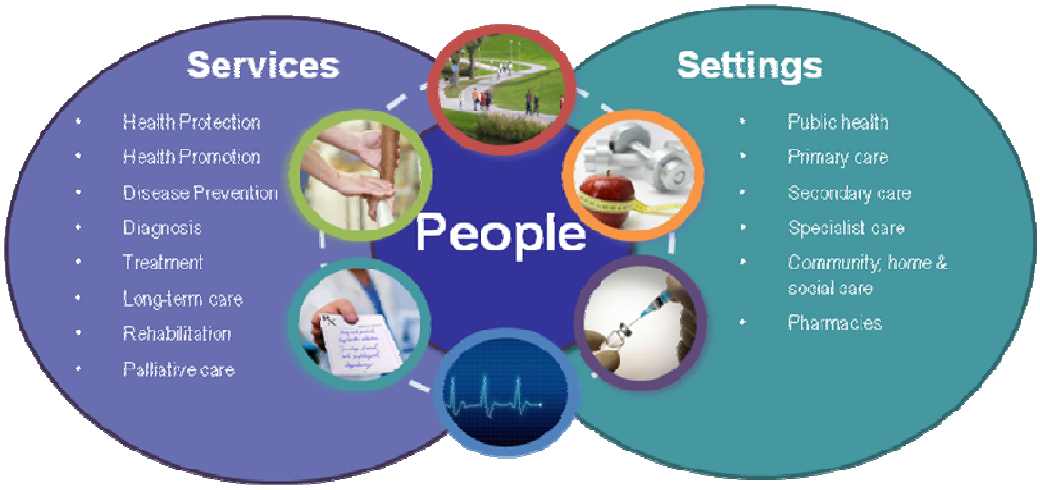
SECTION ONE: THE COORDINATION/INTEGRATION OF HEALTH SERVICES DELIVERY – IN BRIEF

1.1 Defining people-centred, coordinated/integrated health services delivery (CIHSD)

Coordinated/integrated health services delivery (CIHSD)[3] is defined here as the management and delivery of health services such that people receive a continuum of health promotion, health protection and disease prevention services, as well as diagnosis, treatment, long-term care, rehabilitation, and palliative care services through the different levels and sites of care within the health system and according to their needs (adapted from PAHO, 2011). Viewed along a continuum – rather than as two extremes of integrated or not integrated – the CIHSD itself can then be described as a process or tool, serving as a means to secure gains in quality, efficiency and continuity of care and ultimately; to achieve improvements in health status and equity outcomes.

According to the above definition and in its simplest form, efforts towards the CIHSD must consider the services provided and the settings of care, and further, the alignment of the two according to the unique health needs of a given individual (Figure 1.1.1). As shown below, in order to ensure truly people-centred services, priority must be given to provide the "right services" in the "right place" (settings) through strategic processes that allow the complementary and coordinated delivery of services through the lens of an individual and their respective needs and preferences.

Figure 1.1.1 Coordinated/integrated health services delivery defined



Importantly, we note the services considered span the full spectrum of care, encompassing from the essential public health operations (EPHOs) of health protection (EPHO 3), health promotion (EPHO 4) and disease prevention (EPHO 5) to diagnosis, treatment, long-term care, rehabilitation and palliative care. Thinking to the settings of care along this continuum of services, these cut across varied levels and sites to include the broad scope of public health at the

[3] We use 'coordinated/integrated' recognizing the translation of 'integrated' into Russian poses interpretation challenges, holding a different connotation and meaning to that intended here. 'Coordinated' is then used in combination merely for translation purposes and not to suggest a second meaning to the concept of 'integrated health services delivery'.

population and individual level, the central setting of primary care, referrals to secondary care and specialist care, as well as the continuous support of community, home and social care settings and linkages across these settings with pharmacies.

The specific approaches or processes employed creating the linkages between the services and settings may draw from across the health system. This includes for example, efforts to redesign or support the existing workforce in the clinical provision of services, the alignment of incentives to enable and promote the coordination of care across providers, structures to continuously measure the level of system integration, as viewed by objective and subjective people-centred parameters, or an investment in the infrastructure needed to support a shared information system. Redesign efforts also need to consider new professional roles and the skills necessary to work in this changed environment. Strengthening the CIHSD as depicted above is then an effect of the harmonious alignment of services and settings of care through the strategic use of processes that work to manoeuvre the system towards more integrated services.

1.2 Defining related key concepts of CIHSD

The extent to which services along the full continuum of care are experienced in a coordinated/integrated manner can be depicted from the perspective of an individual him/herself. This perspective is described by the concept of continuity of care defined as, "the degree to which a series of discrete health care events are experienced by people as coherent and interconnected over time, and consistent with their health needs and preferences" (PAHO 2011, p. 29).

Focused on providing the 'right care' in the 'right place', CIHSD aligns with the WHO Regional Office for Europe's priority of people-centred health systems – systems in which care is focused and organized around the health needs and expectations of people and communities, rather than on diseases themselves (WHO Regional Office for Europe 2012a; WHO 2010). People-centred care is broader than the closely-related concept of patient-centred care. Whereas patient-centred care focuses on the individual seeking services – the patient – people-centred care encompasses these encounters with the health system while also including attention to the health of people in their communities and the crucial role of citizens in shaping health policy and services (WHO Regional Office for Europe 2012a; WHO 2010). Thus, a people-centred approach takes a unique orientation that is able to recognize that before people become patients, they need to be informed and empowered in promoting and protecting their own heath.

Table 1.2.1 below further notes the distinction between conventional (patient-centred) care and disease-specific programmes, with that of the broad, all-encompassing scope of people-centred health services delivery.

Table 1.2.1 Distinguishing features of people-centred care

Conventional care	Disease-specific programmes	People-centred care
Focus on illness and cure	Focus on priority diseases	Focus on health needs
Relationship limited to the moment of consultation	Relationship limited to programme implementation	Enduring personal relationship
Episodic curative care	Programme-defined disease control interventions	Comprehensive, continuous and person-centred care
Responsibility limited to effective and safe advice to the patient at the moment of consultation	Responsibility for disease-control targets among the target population	Responsibility for the health of all in the community along the life cycle; responsibility for tackling determinants of ill-health and maintaining health
Users are consumers of the care they purchase	Population groups are targets of disease-control interventions	People are partners in managing their own health and that of their community. Their preferences and motivations are integrated into care planning.

Source: (WHO 2008a)

Other key concepts include that of integrated health care networks, introduced by PAHO as a network of organizations that provide or arrange health services in a coordinated contiuum to a defined population and are willing to be held clinically and fiscally accountable for the outcomes and health status of the population served (2011). Integrated health care networks – like the CIHSD as described here – are seen not as an aim in themselves, but rather a means to improve coordination of care and hence, care continuity, quality and efficiency (Table 1.2.2).

Table 1.2.2 Key concepts defined

Integrated health services	Continuity of care	People-centred care	Integrated health care networks
"The management and delivery of health services such that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, through the different levels of care, and according to their needs throughout the life course" (PAHO 2011).	"The degree to which a series of discrete health care events are experienced by people as coherent and interconnected over time, and are consistent with their health needs and preferences" (PAHO 2011, adapted from Haggerty et al 2003).	"Care that is focused and organized around the health needs and expectations of people and communities rather than on diseases" (WHO 2010).	"A network of organizations that provides, or makes arrangements to provide equitable, comprehensive and integrated health services to a defined population and is willing to be held accountable for its clinical and economic outcomes and for the health status of the population that it serves" (PAHO 2011, adapted from Shortell et al. 1993).

1.3 What are the aims and benefits of CIHSD?

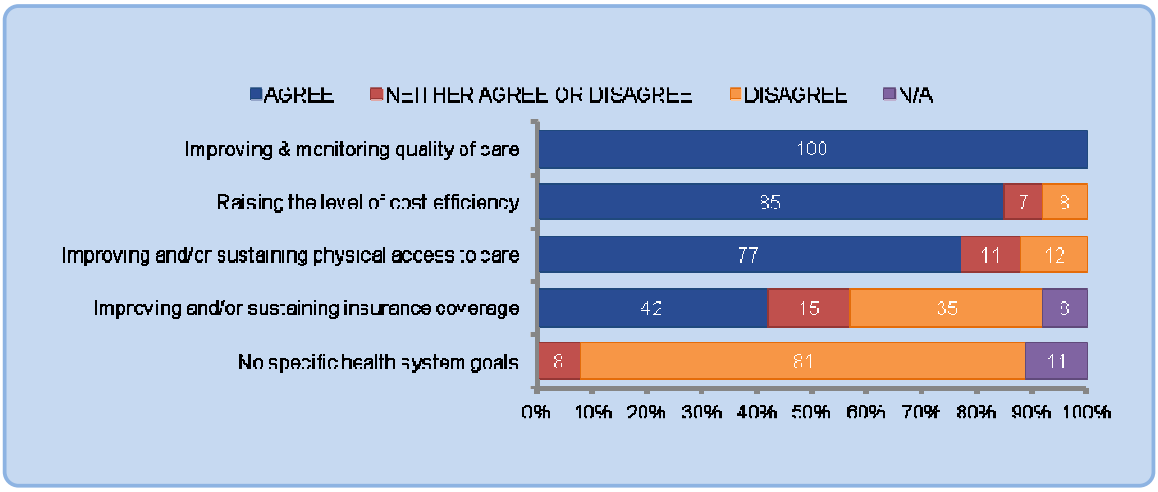
The coordination/integration of health services delivery is an approach to remove gaps in care or poor coordination in care that adversely effect care experiences and ultimately, health outcomes (Goodwin and Smith 2011). The overarching aim of CIHSD is then to overcome the challenges of fragmentation by creating linkages between services along the full continuum of care and to do so according to an individual's needs. Importantly, this does not mean that everything has to be integrated into one package, recognizing as Freeman et al. (2001) point out; discontinuities in

health care are likely inevitable. Rather, the aim is to ensure services are not disjointed from the perception of the service user and that each individual can easily navigate through the system's various levels and settings of care.

The potential benefits of more CIHSD can be viewed from the perspective of a number of health system stakeholders. For the public or patients, more coordinated/integrated services aim to provide a means to reverse or prevent the adverse outcomes of fragmented care, including the over-utilization of medicines, the reduction of redundant work, tests and procedures, adverse hospitalizations and medical errors (RAND 2012). The CIHSD has additionally been said to contribute to ensuring the following: the coordinated transfer and use of information by providers; the empowerment of citizens; improved access to appropriate services; individualized care; consistency in personnel; and a fluid patient-provider relationship (Waibel et al. 2011). For providers and the system-at-large, the coordination/integration of services can contribute to a reduction in the length of hospital stays, decreases in unnecessary hospital admissions and lower numbers of admissions to long-term care (Reed et al. 2005).

As a multi-country questionnaire conducted by the OECD finds, there is overwhelming agreement that policy discussions on the coordination/integration of services are most closely linked with aims to improve the quality of care (Hofmarcher, Oxley, and Rusticelli 2007) (Figure 1.3.1). This by extension impacts on health outcomes and the responsiveness of services to patient needs. To a lesser degree, the questionnaire finds the goals of cost efficiency and ensuring access to services drive the integration of care agenda.

Figure 1.3.1 Main goals of policies to improve care coordination



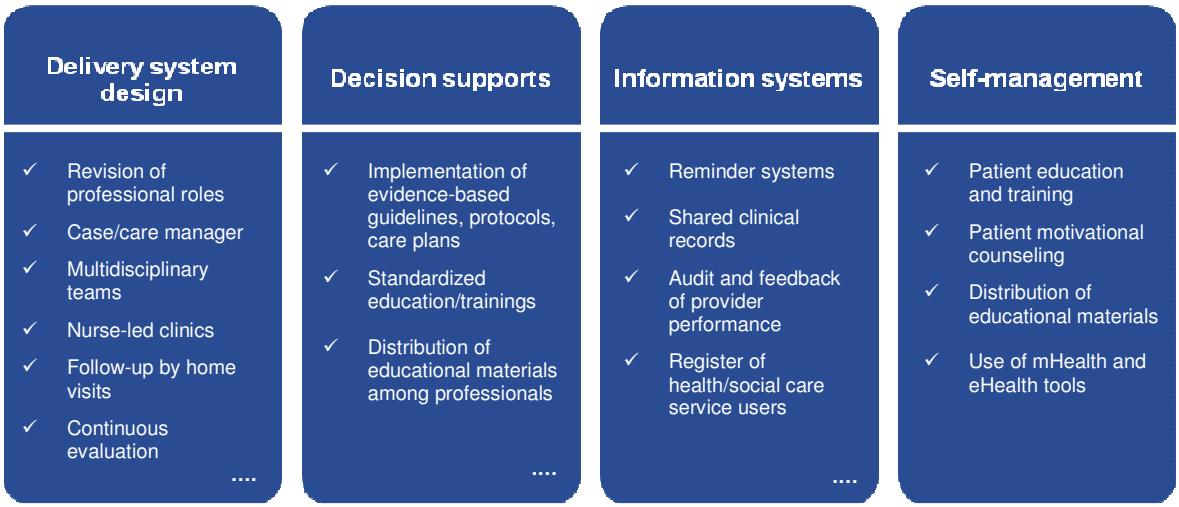
Source: OECD questionnaire on coordination of care 2006, N=26 (Hofmarcher, Oxley and Rusticelli 2007)

1.4 What might CIHSD look like in practice?

A continuously growing literature base has allowed a cataloguing of a range of examples of how CIHSD might be adopted in practice. Some of these initiatives falling under the integration of health services umbrella are outlined below (Figure 1.4.1) aligned with the following orientations common to their approach: system (re-)design in the delivery of services; support and shared information among professionals; improved information integration through the use

of modern technologies (e.g. clinical registries and patient records); and self-management or patient integrated care towards individual empowerment of their personal health needs.

Figure 1.4.1 Examples of initiatives towards the CIHSD



Source: Adapted from Nolte & McKee 2008, citing Zwar et al. 2006

The specific 'integrating initiatives' employed and their strategic combination are very much dependent on the constraints of the existing system and path dependencies, rather than a prescriptive framework or model of services delivery (Powell Davies et al. 2008; RAND 2012; Nolte and McKee 2008). As such, the CIHSD is not likely to follow a single path and variations and changes overtime are to be anticipated (WHO Regional Office for Europe Unpublished).

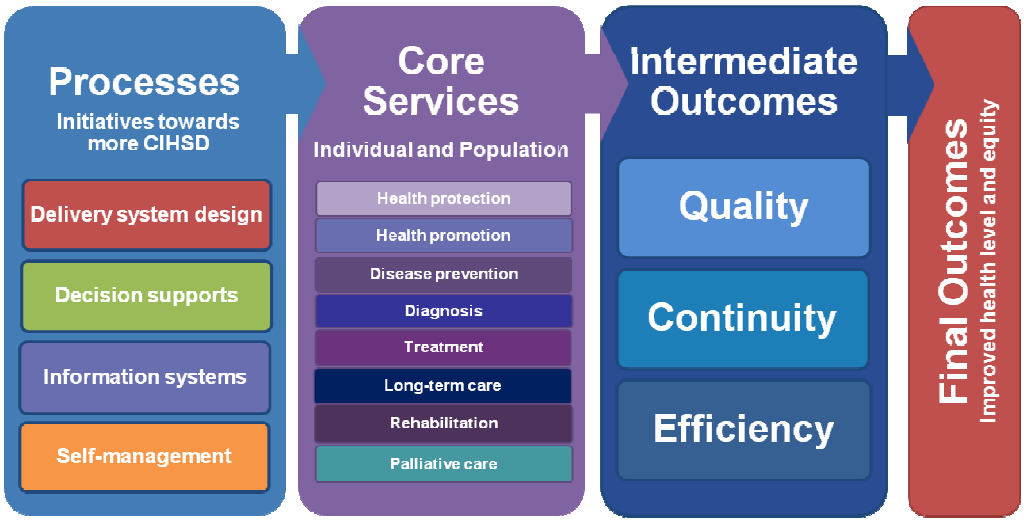
1.5 Improving health outcomes through the CIHSD

The transformation of services towards more coordinated/integrated care is best seen as a means to health system strengthening, rather than as an end it itself. The effects of these transformations are captured below (Figure 1.5.1), depicting the following cascade of relations: (1) the strategic and purposeful use of initiatives towards the CIHSD serve as the entry points to rethinking the delivery of services – applied as individual efforts or in combination with one another. These processes share in their common aim to ensure services are perceived as connected and coherent according to a given individual or service user. (2) The context to which these processes must align is defined by the structure of the health system and must span the full continuum of services as shown below, while also considering the interface between these and varied settings of care – from public health services, primary, secondary and specialist care, to the broader setting of community, social and home care services and the cross-cutting role of pharmacies. (3) In removing health system bottlenecks and barriers through the processes applied linking across core services and settings of care, it may then be possible to secure improvements in the quality, continuity and efficiency of health services delivery (intermediate outcomes) and ultimately in population health level and equity (final outcomes).

We note of particular importance and unique to this approach to HSS through the transformation of services for more CIHSD is the ability to ensure services are delivered in accordance to an

individual's needs and preferences. Improved continuity of care as an intermediate outcome is exclusive to this approach and thus, places the CIHSD as a key priority in order to secure high quality, people-centred health systems that are efficient in the delivery of services, according to the context (epidemiological, demographic, fiscal, environmental factors etc.) to which they must respond.

Figure 1.5.1 Improving health outcomes through the CIHSD



Source: Adapted from WHO Regional Office for Europe 2012b

1.6 What does the evidence say?

There is now a wide range of evidence on specific interventions or initiatives towards more CIHSD. This literature base agrees with growing consensus as to the potential for positive outcomes to be secured for the quality and continuity of care. Commonly cited gains include improvements concerning hospital utilization, quality of life, functional health, patient satisfaction and on process outcomes, such as adherence to guidelines and compliance with medication (Ouwens et al. 2005). Further identified advantages include improved access to appropriate levels of care (Ovretveit 2011; Banks 2002), as well as better individual experiences with care received (Ovretveit 2011). Importantly, the evidence does suggest that the impact of coordinated/integrated services may vary according to the pathology under consideration, and thus caution should be taken when interpreting and generalizing gains.

Some examples of these main messages from the literature and specific studies or contexts in which gains have been reported are described in Box 1.6.1 to follow.

Box 1.6.1 Evidence on the CIHSD – examples from the literature

- **Decreased hospitalizations, length of hospitalization or hospital readmissions.** In the United Kingdom (UK), a reduction of up to 27% in total number of day beds for emergency admissions for chronic illnesses between 2007 – 2009 was observed following integrated care pilots for people living with multiple chronic illnesses (Goodwin and Smith 2011).
- **Improved patient compliance and patient knowledge about their condition.** A review of a collaborative model programme for chronic health failure finds patients of providers participating in the programme were more knowledgeable, used recommended therapies more often and visited the emergency department less than those not participating in the model for more CIHSD (Coleman et al. 2009).
- **Improved patient satisfaction.** A review of integration studies (n=85) finds an overall increase in service-user or patient satisfaction in 45.2% of cases. The greatest improvements were secured in patient health outcomes (55.4% of cases), with least improvements in cost-savings (Powell Davies et al. 2008).
- **Improved access to appropriate health services.** An urgent care-tracking dashboard in the primary health care setting of the UK NHS observed a decrease in hospital admissions by 3% against a regional increase of 9% (Goodwin and Smith 2011). Unscheduled hospital admissions additionally fell by 4%.
- **Gains in cost-efficiency [inconsistent data].** A systematic review found that clinical coordination can save money, however, it depends on which approach is used, how well it is implemented, and on the features of the environment in which a provider is operating, including the financing system (Ovretveit 2011). Ultimately, short-term cost increases are to be anticipated, estimated in a study on improving diabetes care coordination as an additional $6-$22 per patient in the first year of implementation (via expenses related to the redesign of services) (Huang et al. 2008).

Evidence is also available capturing the gains of more CIHSD from the perspective of the individual service user and health care provider. For example, a meta-synthesis of qualitative studies on continuity of care suggests some positive outcomes when continuity is perceived in the delivery of services (Waibel et al. 2012). When there is consistency in health providers (relational continuity), users report that they receive the right information at the right time and in a sensitive manner. Furthermore, seeing the same provider is found to improve care plans, support the mutual understanding of needs and encourage a sense of responsibility for an individual's health status (Waibel et al. 2012). In addition, a systematic review of the association between continuity of care and outcomes strongly suggests that increased provider continuity is associated with improved health utilization and user satisfaction outcomes (van Walraven et al. 2010). Box 1.6.2 captures directly from the patient or provider some of their experiences with more CIHSD.

Box 1.6.2 Patient & provider perceptions of coordinated/integrated services

"The main services here are all routine, so we know when doctors are here and we can meet anyone we need to. We feel like there are people who really care about us here."
(Service user, integrated HIV and services for injection drug users, Kriviy Rig Narcological Dispensary, Ukraine)[a]

"The visits with the GPs are more regular and by seeing them with more regularity, there is more trust."
(Service user, integrated care network for chronic obstructive pulmonary disease, Catalonia)[b]

"My GP knows, without having to look at the computer, he knows what illnesses I suffer from and from which I don't."
(Service user, integrated care network for chronic obstructive pulmonary disease, Catalonia)[b]

"Multidisciplinary teams allow us to have much more control over our patients care, with much better and more regular follow-up."
(Provider, Crimean Republican Narcological Dispensary, Simferopol, Ukraine)[a]

"Very often they (primary care providers) call me or send me an e-mail when they have a problem. I think that's agile and communication exists, and above all it's easy to realize."
(Pulmonologist, integrated care network for chronic obstructive pulmonary disease, Catalonia)[b]

Sources:
[a] Curtis, M. 2010.*Building integrated care services for injection drug users in Ukraine.* Copenhagen: WHO Regional Office for Europe.
[b] Waibel, et al. 2013.*The performance of integrated healthcare networks: analysis of continuity of care.*" (In review).

SECTION TWO: CONTEXT OF CIHSD IN THE REGION

2.1 Regional trends driving the CIHSD agenda

Health services need to continuously adapt to emerging changes and central to improving the performance of health systems are transformations in how these services are delivered. At present, a number of factors are found to drive the needed transformations in services delivery across the European Region. These factors are understood importantly to include the following: shifting population demographics, as the population in the European Region is living longer than ever before with a life expectancy at birth among Member States averaging 76.6 years in 2011, while fertility rates continue to fall (averaging 1.64 in 2011) (WHO Regional Office for Europe 2012c); a rise in non-communicable diseases (NCDs) and related multi- and co-morbidities, with NCDs accounting for the largest proportion of mortality and premature death (approximately 87 percent of all deaths annually) (WHO Regional Office for Europe 2012c); the persisting challenge to control the spread of emerging and re-emerging communicable diseases, including HIV-infection and tuberculosis as well as those triggered by the changing environment and patterns of movement (thinking to international travel and migration) that heighten the international threat to health security through the spread of vaccine-preventable, foodborne and zoonotic diseases; and finally, the increasing expectations of citizens as education levels continue to rise and information becomes more readily available (Kickbusch & Gleicher 2012).

A misalignment between these challenges of today and existing models of care has subjected services to obstacles including the overuse, underuse and misuse of services, uncoordinated arrangements in the delivery of care, a bias towards acute treatment and the neglect of preventative and social care (WHO Regional Office for Europe Unpublished). Furthermore, a number of shortcomings in the structure and function of health services delivery persistently undermine progress towards people-centred, coordinated/integrated services. This includes a disproportionate focus on specialist, tertiary care, which has become a major source of inefficiencies and inequalities in the delivery of health services across the Region (WHO Regional Office for Europe 2013c).

Fragmentation in the delivery of services and insufficient and ineffective coordination and communication between different levels and sites of care are enduring challenges in the delivery of services (WHO 2008a). Leading causes of fragmentation and poor coordination in the Region include: programmes targeting specific diseases, risks and populations without integrating into the health system (such as vertical HIV or TB-specific programmes) (Moore 2003); the decentralization of health services that fragment the level of care (WHO 2008a); an absence of incentives and financial policies conducive to strengthening the coordination of care (WHO Regional Office for Europe 2012a); and a lack of evidence-informed pathways for the whole continuum of a care episode (WHO Regional Office for Europe 2012a).

Importantly, in the context of the global financial crisis – felt to varying degrees across the Region – the challenges of social protection have been exacerbated. Moreover, in this era of continuous advancements in medical technology, there is added strain on already limited resources to implement even modest investments to overcome shortcomings in the structure of services delivery.

As summarized in Table 2.1.1 below, it is in the context of the incongruence between the health demands at present and the available resources dictated by existing service delivery structures that transformations in health services delivery have been necessitated.

Table 2.1.1 Main driving forces for health system reforms towards more CIHSD

Demand-side	Supply-side
• Demographic changes • Increasing burden of non-communicable diseases, multi- and co-morbidities • Persisting challenges to prevent and control emerging and re-emerging communicable diseases • Rising patient expectations • Changing global climate and threats to international health security	• Fragmentation of services and sub-specialisation • Hospital centrism - diverting from PHC values and public health services • Resource constraints and rising costs • Advancements in technology • Growing evidence and awareness of the adverse impacts of fragmented care

2.2 Experience of Member States towards more CIHSD

Across the Region, reforms in the delivery of care towards more integrated services have widely emerged in acknowledgement of sustainability and quality concerns and the need for more equitable, comprehensive, integrated and continuous responses on the part of the health system. While the specific 'integrating initiatives' applied and their strategic combination are found to vary by a given context and a system's related path dependencies, these efforts ultimately share in their aim to overcome the challenges of fragmentation in the provision and financing of health care services.

Examples of initiatives have been studied and catalogued by a number of sources (see for example, Nolte & McKee 2008; Zwar et al. 2006; Kodner & Spreeuwenberg 2002). We highlight a small sample of these below while attempting merely to acknowledge the diversity in approaches for each intervention according to their unique aims.

Table 2.2.1 Experiences of Member States towards more CIHSD

COUNTRY	AIMS	DESCRIPTION	OUTCOMES
Estonia[i]	*To fully integrate communication through a national electronic health record system, linking across levels and sites of care*	▪ National electronic health record hosting over 3,000 e-services and companion health insurance system for claims, reimbursement and prescriptions ▪ Implementation costs equivalent to approx. $10 USD per citizen	▪ Efficiency gains via the direct communication between institutions and providers ▪ Engagement of individual receiving care via personal health record, virtual medical center and mobile patient applications
Germany[ii]	*To implement integrated care pathways for selected treatments towards improved rehabilitation of patients for the return to work sooner*	▪ Integrated contracting model for coordination between case managers, doctors, psychiatrists & physiotherapists ▪ Selected procedures (e.g. pain therapy); targeted population	▪ Patients treated through integrated networks found to return to work 72 days earlier than those treated through conventional care pathways

COUNTRY	AIMS	DESCRIPTION	OUTCOMES
Hungary[iii]	*To coordinate the delivery of services and collaboration of providers in primary care*	▪ Capitated budget for participating group practices to cover all primary care services of a given population ▪ Incentives for prevention services and retained savings of practices for reinvestment	▪ Improved collaboration among providers ▪ Decrease in inappropriate services ▪ Increased attention to preventive services
Israel[iv]	*To provide an integrated network of hospitals, primary and specialized clinics and pharmacies towards high quality, people-centred care*	▪ Services adapted to unique population sub-groups ▪ Prioritize innovative care models targeting continuity of data, care transition, & strengthening hospital-community care linkages	▪ Improvements in preventing hospital readmission ▪ Strong continuity of care via attention to patient preferences and home and community support systems in place ▪ Marked and sustained reduction in health and healthcare disparities
Ukraine[v]	*To develop integrated services for people with a history of injection drug use as part of the country's ongoing response to the HIV epidemic*	▪ Integrated harm reduction and HIV treatment programmes ▪ Innovations including pharmacy-based needle exchanges, overdose prevention services, new programmes targeting stimulant users, and improved case management services	▪ Improved HIV treatment outcomes while also reducing illicit drug use through improved adherence to treatment and retention in care ▪ Improved user satisfaction

Notes: i. For further information, see for example: Estonian eHealth Foundation (2013). *Health information system.* Retrieved from http://www.e-tervis.ee/index.php/en/health-information-systems.
ii. Initiative of Techniker Krankenkasse – Statutory health Insurer. See for example: Wagner, C. (2012). *Lessons from German: Implementing integrated care as a statutory health insurer.* London: The Kings Fund.
iii. For further information, see for example: Evetovits (2011). *Exploring new ways to pay health providers and improve performance.* Barcelona: WHO Barcelona Office for Health System Strengthening.
iv. Balicer, R. (2013). *Clalit health services.*(powerpoint) for the WHO Regional Office for Europe.
v. For further information, see for example: Curtis, M. (2010). *Building integrated care services for injection drug users in Ukraine.* Copenhagen: WHO Regional Office for Europe.

2.3 Challenges in reforming the delivery of health services

Marked gains of more CIHSD from across the Region have motivated continued efforts to initiate, implement and/or scale-up initiatives to transform services delivery. Moving this agenda forward at scale and pace, however, faces a number of challenges, summarized as follows:

1. **Lacking capacity to scale-up location and/or disease specific initiatives.** Initiatives towards the coordination/integration of health services delivery are commonly driven by the local efforts of specific facilities or health care providers. While responding to the unique needs of a given sub-group of the population or a geographic area, these changes are often incremental, lacking the needed leadership and managerial capacity to bring efforts to scale.

   To support those in leadership roles tasked with the management of these processes, an arsenal of policy tools and instruments are needed. This is of particular pertinence in the context of contemporary health systems, as the boundaries of the system have become increasingly blurred and the relationships and lines of accountability between actors – largely ambiguous.

2. **Persisting health system bottlenecks.** Incremental changes ultimately do not address persisting health system bottlenecks contributing to fragmentation and lack of coordination in the delivery of services. Moreover, it is recognized that continued incremental changes will not necessarily create the linkages needed for efforts to be fully embedded within the system

(Powell Davies et al. 2008). In failing to apply a systems-orientation, efforts are then at risk of perpetuating fragmentation by existing in silos of integrated practices themselves. For sustained gains in the integration of services to be realized, fundamental reforms acting across health system functions are needed. This requires for example, the systems-thinking to implement information technology that enables the coordination of communication across levels and sites of care, contracting models conducive to collaboration among providers, and/or payment incentives that are complementary in motivating integrated efforts. Further efforts are needed to communicate this systems-thinking with key partners and to translate this approach into practical policy options.

3. **Advocating the coordination/integration of services in times of financial hardship.** In the context of the current financial crisis austerity measures are high and efficiency in the delivery of services is a priority for reform efforts. Inconsistent data on efficiency gains for the CIHSD, in addition to possible short-term investment costs, pose a significant challenge to advocating the interventions needed for the integration of services. Ultimately, advocacy efforts must give priority to communicating the long-term gains in quality and continuity of care and the precedence this must take in order to achieve people-centred health systems.

2.4 Work to-date at the Regional Office supporting health services delivery

Within the Division of Health Systems and Public Health, a number of products and activities for thinking to modern health care delivery systems and the integration of care have been developed or are in progress. These efforts are catalogued below in table 2.4.1. These include, for example, earlier thinking to the hospital sector (e.g. Rechel et al 2009) and country-specific efforts for health system strengthening, such as the work of Edwards (2011) “Improving the hospital system in the Republic of Moldova”. Thinking to the primary care setting, there remains the continued implementation of the primary care evaluation tool (PCET) as well as a horizontal analysis of countries where this tool has been applied. At present, a series of efforts are underway to contribute to early discussions on the coordination/integration of services in the region. This includes for example, work to finalize a background paper on integrated health care delivery as well as the implementation of country case studies towards the synthesis of tools supporting the development of a guide for change management to further country-specific implementation of coordination/integration in the delivery of services.

While this work has undoubtedly contributed to the discussions on integrated care in the Region, in the absence of an overarching, common framework or approach to streamline products, the potential to adequately respond to the challenges in furthering efforts towards the CIHSD remains limited. Moreover, a clear narrative of the experiences of Member States has yet to be realized despite the importance of this in communicating lessons learned from across the Region.

Recognizing the context of the Region driving the integrated care agenda and the momentum among Member States to implement initiatives, a concerted effort to overcome existing challenges, generate and exchange information on experiences and provide implementation support and technical capacity is of great pertinence. This need is echoed by the call of Member States for evidence-based policy options as ‘how-to’ instruments for the coordination/integration of services. Responding to this context and call of Member States, the Regional Office must then build on existing efforts and prioritize work to support the coordination/integration of services in the Region.

SECTION THREE: A FRAMEWORK FOR ACTION TOWARDS CIHSD

3.1 Aim and key objectives

The Framework for Action towards CIHSD is envisioned as a resource to support the CIHSD towards more people-centred health systems such that improvements in health level and equity may be fully realized. To do so, the Framework for Action towards CIHSD intends to consolidate and align the literature on the CIHSD towards a common analytical understanding of the concept further informed by the first-hand experiences of Member States to-date. Importantly, the approach taken will be grounded from a systems-orientation such that efforts are oriented to address persisting health system barriers to the coordination/integration of health services delivery.

Hearing the calls of Member States for evidence-based policy options, priority has been given to ensuring the final output of this long-term work plan includes translating the knowledge and experiences generated into common denominator policy options. These contextualized tools are envisioned to take shape in a change management guide intended as a resource to support Member States in their efforts to initiate, implement and scale-up the coordination/integration of services. As a mediator for the exchange of information, the Regional Office aims to continue to support the objective of knowledge and experience sharing throughout the development and into the implementation of the Framework for Action towards CIHSD.

Box 3.1.1 Aim and key objectives of the Framework for Action towards CIHSD

Aim: To support the coordination/integration of health services delivery towards more people-centred health systems such that improvements in health level and equity may be fully realized.

Key objectives:

1. To consolidate and align literature on the CIHSD towards a common analytical understanding of the concept.
2. To provide a common approach for the accelerated exchange of experiences across the Region towards more CIHSD.
3. To decipher common denominator policy tools and instruments to initiate, implement and/or scale-up efforts towards the CIHSD.
4. To support Member States in building technical capacity and needed leadership and managerial skills for sustained coordination/integration across health systems.
5. To meaningfully engage a diverse number of partners in discussions and consultations throughout the processes defined.

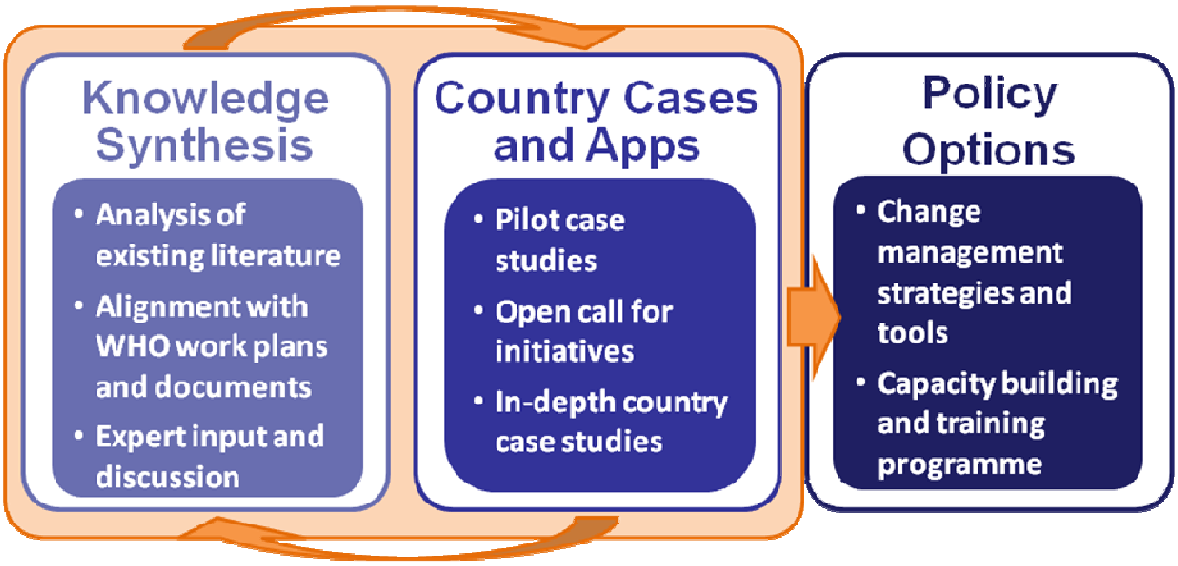
The process itself for developing the Framework for Action towards CIHSD is envisioned as a vehicle for generating the technical capacity, leadership and managerial skills needed in-country for CIHSD priorities to be realized. At the policy level, for example, this includes tools and skills for participatory, multi-disciplinary priority setting demanded for the coordination/integration of

care that crosses the continuum of sectors, levels and sites of services delivery. To this end, continuous consultations and opportunities to engage with national and sub-national actors have been defined in the processes towards its development.

3.2 Platform for work in developing a Framework for Action towards CIHSD

Three core areas of activity form the technical dimensions of the Framework for Action towards CIHSD: (1) knowledge synthesis – a review of literature towards a compelling narrative for the CIHSD, giving structure for further study by developing an analytical framework for systems-thinking towards the CIHSD; (2) field evidence – a series of country case studies, capturing experiences across the Region to initiate, implement and scale-up initiatives to strengthen the CIHSD; and (3) policy options – informed by the first two areas of activity, taking shape as common tools for change management in a resource guide for the implementation of transformations in the delivery of services (Figure 3.2.1).

Figure 3.2.1 Platform for work in developing a Framework for Action towards CIHSD



1. **Knowledge synthesis towards a common analytical approach to thinking of CIHSD.** The process of knowledge synthesis intends to pull together existing literature related to the CIHSD into a common narrative for the main aspects of study in this area. Work along this area of activity will allow a clear overview of the CIHSD, addressing conceptual issues of relevance while importantly, orienting CIHSD thinking from a systems approach. Ultimately, the process of knowledge synthesis aims to understand what the current challenges are, where gaps in knowledge lie and how contributions towards further understanding can be made. The final output of work along this line of activity will take the shape of a concept note defining a common analytical approach to the CIHSD that will inform across the components of the Framework for Action towards CIHSD.

2. **Field evidence of country experiences from across the Region.** Country case studies form the second area of work, allowing insight into the CIHSD through the first-hand experiences of Member States. Work within this second pillar aims to leverage the experiences of each country in their efforts plan, implement and scale-up initiatives to deliver more coordinated/integrated care. Recognizing the diversity in initiatives and efforts towards more CIHSD, the approach to identifying case studies itself will take that of an open call for a summary of practices from across the Region. Welcoming submissions of practices from the public and private sector and at various levels and sites of care, this effort aims to generate a strong understanding of the work that has been done across Member States to date.

   From these descriptive profiles of CIHSD initiatives across the Region, a sub-set of experiences will be selected for further in-depth review. Identifying these specific cases for further study will consider a number of factors including representation from across the Region and the different components of the CIHSD framework defined. These in-depth case studies intends ultimately to capture information on more explanatory variables – 'how', 'what' and 'why' dimensions to reforms in the delivery of services, asking for example, "*what* was the priority area to which the CIHSD was intended to respond?" or "*how* did a country go about implementing efforts towards more CIHSD?" The expanded list of practices is envisioned to take shape as an electronic compendium and both these and the fully developed case studies will inform the consolidated policy options to be consolidated in the guide for change management according to the third pillar of work.

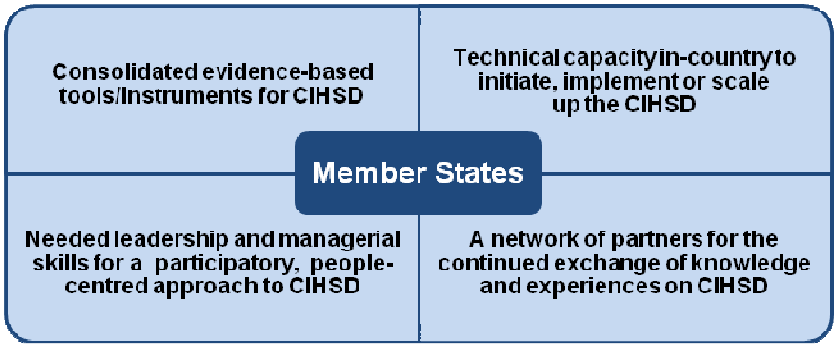
3. **Policy options as lessons learnt for needed leadership and change management.** To support the transfer of knowledge and experiences synthesized in the first two areas of work, attention will be given to deciphering a priority list of evidence-based actions or policy options (tools) towards the CIHSD. Taking the experiences of the countries, the findings can be shared beyond an understanding of *what* can be done to sharing also *how* countries were able to move from an initial point or context to their specific system goals. Work along this area includes efforts to generate policy dialogue and support countries in developing the technical capacity and leadership skills needed for sustained change. Included here are also tools for monitoring and evaluation, to ensure the necessary information is generated (e.g. measures to capture the perspective of the public to inform an understanding of the continuity of care) and further, the appropriate interpretation and application of this information for continued improvements.

3.3 Expected final outputs and outcomes

The final Framework for Action towards CIHSD defined by the components described above is to be presented to Member States for their endorsement and agreement to prioritize the CIHSD at the 66th meeting of the Regional Committee for Europe in 2016. The Framework presented at that time will reflect the culmination of knowledge and experiences from across the Region as well as the various consultations and review processes to generate buy-in while further building capacity among Member States.

For Member States, the added value of this work plan and the envisioned Framework for Action towards CIHSD can be summarized as the following (Figure 3.3.1):

Figure 3.3.1 Added value of Framework for Action towards CIHSD for Member States



- **Consolidated evidence-based tools/instruments for CIHSD.** The technical knowledge and experiences generated through this work plan will equip Member States with an arsenal of policy options that are informed by the experiences of countries and that can be applied according to their respective priorities and needs.

- **Technical capacity in-country.** The participatory processes and periods of consultation defined will ensure Member States have the capacity in-country to advocate for the CIHSD in their health systems and ensure the implementation and scale-up of coordination/integration priorities are realized.

- **Leadership and managerial skills for change management.** The change management tools developed in the envisioned guide as the third component of this work plan will ensure the technical agenda of CIHSD is supported by needed leadership and managerial skills for long-term planning, change management, and the continuous monitoring and evaluation for feedback to further inform transformations in services delivery.

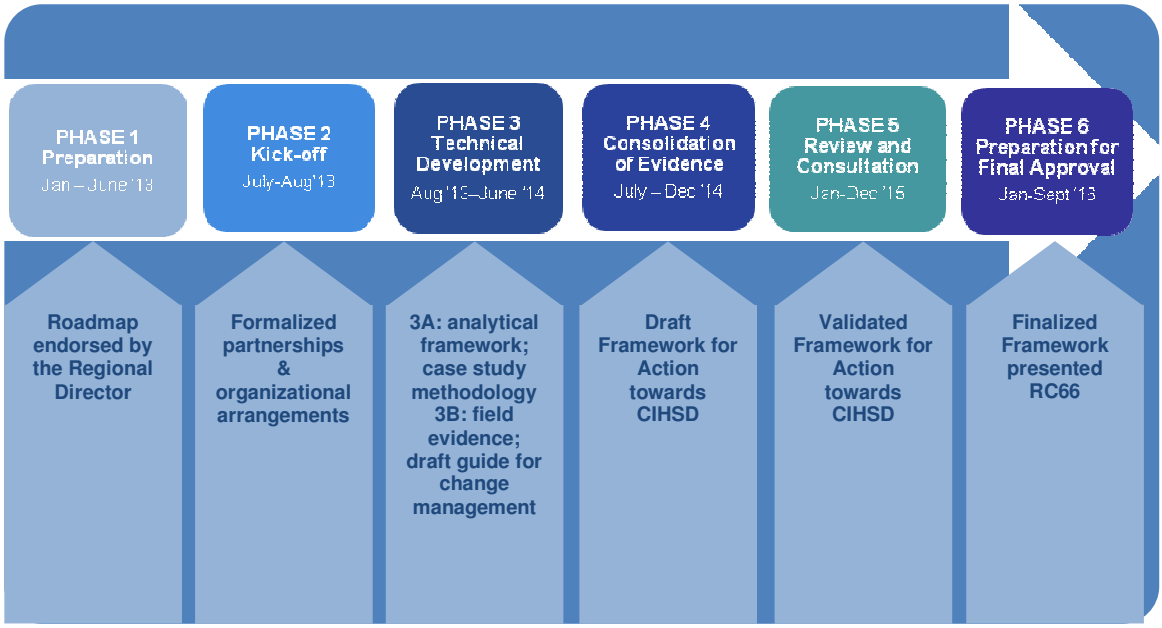
- **A network of partners for the continued exchange of knowledge and experiences.** Coordinating across Member States and with sub-national and international partners, the processes towards the Framework for Action towards CIHSD will allow strategic partnerships across and within countries for continuous dialogue and exchange of experiences.

SECTION FOUR: PHASES OF ROADMAP

4.1 Overview: Six phases of Roadmap

Six phases for the development of the Framework for Action towards CIHSD are defined extending from present to the WHO Regional Office for Europe's 66th Regional Committee Meeting in September 2016. Key processes and the intermediate outputs aligned with each phase are developed to follow. Particular attention has been given to note opportunities for formal consultation with Member States and internal and external teams in order to ensure a participatory approach across each of the phases defined in Figure 4.1.1 below.

Figure 4.1.1 Phases and outputs of the Roadmap for the development of the Framework for Action towards CIHSD



Ultimately, the Roadmap for the development of the Framework for Action towards CIHSD has been defined according to the following key objectives:

1. To provide an overview of the core phases and respective processes from present to RC66 in 2016 in developing the Framework for Action towards CIHSD;
2. To facilitate/create opportunities for pragmatic collaborations – both in-house and external – and consultations with Member States across the processes defined;

To maximize ongoing and future technical work on CIHSD at the Regional Office.

4.2 Phases of the Roadmap

PHASE ONE: PREPARATION

Duration: January 2013 – June 2013

Key processes:
1.1 Drafting of Roadmap document for the development of the Framework for Action towards CIHSD
1.2 Generating buy-in of key partners (in-house and external)

Output: Roadmap for the development of the Framework for Action towards CIHSD endorsed by the Regional Director

1.1 Drafting of Roadmap document for the development of the Framework for Action towards CIHSD

The document at hand will serve as a planning tool to map key phases and processes in the development of the Framework for Action towards CIHSD. The document intends to generate discussion and elicit feedback from key partners while also serving as a platform internally to align current and on-going work. The Roadmap is envisioned as a living-document to be revised and expanded through various iterations, reflecting the feedback received during this initial preparatory phase.

1.2 Generating buy-in of key partners (in-house and external)

Throughout the preparatory phase, opportunities to engage with key partners will be pursued in an attempt to generate buy-in both in-house and with external contacts. To this end, a series of presentations and discussions have been convened as settings for sharing the envisioned Framework for Action towards CIHSD, while additionally flagging opportunities for collaborations. These presentations and consultations to date are summarized in table 4.2.1. This process has included discussions within the HSD Programme, across Programmes of the Division of Health Systems and Public Health and with Directors and staff from each of the Divisions in-house. External engagement has included participation and presentations at the International Conference on Integrated Care in Berlin (April 2013) and the World Hospital Congress in Oslo (June 2013). All feedback received through these presentations has been consolidated and consideration has been given to address or acknowledge how best to ensure each point is responded to.

PHASE TWO: KICK-OFF

Duration: July 2013 – August 2013

Key processes:
2.1 Contracting of Coordinator and consultants
2.2 Formalizing the Expert Advisory Team
2.3 Formalizing the Internal Review Team
2.4 Appointment of Member State focal points
2.5 Formalizing communication strategy (in-house/external)

Output: Formalized partnerships and organizational arrangements

2.1 Contracting of Coordinator and consultants

A consultant will be contracted to oversee both technical and logistical tasks for developing the Framework for Action towards CIHSD. The Coordinator of this work plan will be based within the HSD Programme under the supervision of the Programme Manager (see Figure 5.1.1). External consultancies are additionally anticipated for the development and coordination of country case studies as well as in support for carrying out the case studies themselves.

Immediate lines of activity for the Coordinator of the Framework for Action towards CIHSD include the following:

- Technical preparation of the concept note and coordination to align in parallel the development of the country case study methodology;
- Logistical and technical preparations for reviews of the Internal Review Team and Expert Advisory Team;
- Logistical and technical preparations for consultations with Member State focal points;
- Finalization of validated concept note and case study methodology.

2.2 Formalizing the Expert Advisory Team

An Expert Advisory Team will be assembled, with priority given to include experts with varied technical expertise in the following areas: integrated care; health services delivery; public health; primary health care; health systems; change management; and hospitals. Effort will additionally be made to ensure representation of expertise from across the Region. Efforts to formalize will include the written agreement of focal points following an invitation to be engaged as partners in this process.

The Expert Advisory Team is envisioned to provide input on key technical aspects in the development of the Framework for Action towards CIHSD. This includes thematic aspects and defining the scope of an analytical framework as well as the alignment of the framework with the methodology for country case studies. The Coordinator of this work plan will serve as the focal point for the Expert Advisory Team, being responsible for planning and managing opportunities for timely, pragmatic discussions throughout the phases defined (see section 5 for partnerships further described).

2.3 Formalizing the Internal Review Team

An Internal Review Team will be established across Divisions of the Regional Office. This multi-disciplinary team is intended to peer-review products of the Framework for Action towards CIHSD across phases to ensure all are of high-quality and in line with overarching priorities of the Office, specifically those of Health 2020. Additionally, the Internal Review Team is intended to ensure opportunities for collaborations across Divisions are identified and that in-house technical expertise and experiences are maximized (see section 5 for partnerships further described).

The Coordinator will serve as the focal point for the Internal Review Team. The specific membership of the team intends to capture a number of technical areas across Divisions in-house.

2.4 Appointment of Member State focal points

All Member States will be requested to nominate a country focal point to represent their views and to provide input and regular feedback on all aspects of the Framework for Action towards CIHSD. This network will be managed by the Coordinator, with opportunities to comment on all

technical products throughout the phases defined. The focal points will additionally be requested to support the process of identifying country experiences to be considered for case studies as well as country counterparts to be contracted in the process of carrying out this work (see section 5 for partnerships further described). First contact in appointing focal points will be made with the existing network of WHO Representatives (WRs) to assist in identifying an appropriate representative with expertise on the CIHSD in the country.

2.5 Formalizing a communication strategy

A means for internal communication to share updates, exchange resources and maintain transparency throughout each phase will be explored (e.g. strategic use of the Intranet or a similar electronic share point, lunch box seminars inviting staff from across Programmes and Divisions, occasional email updates, etc). Approaches for communicating with a wider audience (e.g. international organizations, national actors, public) will be defined in order to best position this work across the Region. To this end, support of in-house communication experts will be solicited.

PHASE THREE: TECHNICAL DEVELOPMENT

Duration: August 2013 – June 2014

3A: Analytical development
3.1 Preparation of concept note
3.2 Developing case study methodology
3.3 Review by external and internal teams
3.4 Consultation with Member State focal points

Output: Analytical framework and annotated outline of the Framework for Action towards CIHSD; Methodology for country case studies

3B: Developing the evidence-base
3.5 Conducting case studies
3.6 Identifying tools for change management
3.7 Review by external and internal teams
3.8 Consultation with Member State focal points

Output: Field evidence; Draft resource of tools for change management

3A. Analytical Development

3.1 Preparation of concept note

A concept note will be developed to provide an analytical framework for the Framework for Action towards CIHSD. The process for developing the framework will draw on a review of existing literature and earlier work in Division of Health Systems and Public Health on coordinated/integrated care. The analytical framework defined through this process will then serve as the overarching approach to which subsequent technical work will be aligned (e.g. country case study methodology). The Coordinator will oversee the drafting of the concept note. Technical comments raised during the initial preparatory phase will be addressed at this time.

3.2 Developing case study methodology

A standard case study methodology will be developed in parallel with the preparation of the concept note to ensure the alignment in the key components defined (3.1). In an attempt to

capture the diversity in experiences and approaches towards the CIHSD, an open call for submission of practices will take place, inviting organizations of the private and public sector, providers or patients themselves to recommend a practice to be shared. A common approach will be defined to generate a descriptive synopsis of each and ensure consistent inclusion criteria for the practices captured (e.g. must be beyond the piloting phase; efforts must have data monitoring implementation and outcomes). From the initiatives captured, a sub-set will be selected for further in-depth review.

The case study methodology will be developed by an external consultant, contracted to support both the technical development of the case studies as well as to manage the related network of countries and staff for implementation (field-work, drafting of studies, etc.). Technical comments raised during the initial preparatory phase will be addressed at this time.

3.3 Review by external and internal teams

Following the preparation of the concept note and related case study methodology, opportunities for feedback and discussion with the Expert Advisory Team and Internal Review Team will be convened. The Coordinator will manage the appropriate timing and setting for this. These reviews will be followed by a period of further revision in which the feedback received will be taken into consideration and reflected in later drafts.

3.4 Consultation with Member State focal points

A similar review process will involve consultation with the forum of Member State focal points on both the concept note and related case study methodology. The Coordinator will oversee this consultation process and a similar period of revision will follow to ensure modifications in line with the feedback received.

3B. Developing the Evidence-Base

3.5 Conducting case studies

Applying the case study methodology, a series of country studies will be carried out across the Region. The specific number of studies, countries, and experiences for consideration will be dictated by the analytical framework and methodology itself. A series of consultants in-country will be contracted to support the process of data collection. An external consultant will manage the network and implementation of the country case studies and the necessary preparations for this process (e.g. workshops to train consultants for consistent application of the methodology developed).

3.6 Identifying tools for change management

In parallel and with inputs from country experiences, a synthesis of tools for change management will be drafted to accelerate the implementation of the Framework for Action towards CIHSD in Member States. Aligning with the analytical framework, the tools intend to share lessons learnt from country experiences on the leadership and management skills needed to enable needed changes towards more coordinated/integrated care as well as related actions for the sustainability of efforts. These tools, as policy options for change management may also include approaches taken to the monitoring and evaluation of efforts in order to ensure that information is generated effectively and applied in-turn to inform continuous improvement efforts in the delivery of services.

3.7 Review by external and internal teams

The evidence generated through the fieldwork described will be followed by a similar review process to that of the more conceptual products of 3.1 and 3.2. Both the external and internal teams will be convened for discussion and feedback on the findings from the country case studies and synthesis of tools for change management. This process of review will additionally allow an early opportunity for the interpretation of country findings.

3.8 Consultation with Member State focal points

A process for consultation with Member State focal points will be convened in order to share country findings and synthesize tools for change management. Findings will also be validated in the countries of study to ensure accurate interpretation of the experiences captured.

PHASE FOUR: CONSOLIDATION OF EVIDENCE

Duration: July 2014 – December 2014

Key processes:
4.1 Alignment of concepts, findings and other background documents
4.2 Synthesis of evidence-based policy options

Output: Draft Framework for Action towards CIHSD: (1) Concept note; (2) Field evidence; (3) Tools for change management

4.1 Alignment of concepts, findings and other background documents

Products developed in earlier phases as well as existing and ongoing work in the Division on Health Systems and Public Health will be consolidated to align with the three main chapters (components) of the Framework for Action towards CIHSD: (1) a concept note on CIHSD; (2) field evidence of country experiences; and (3) a resource guide for leadership and change management towards more CIHSD. The reflection process to align this work will be guided by the Coordinator and within the overarching scope and vision of the analytical framework.

4.2 Synthesis of evidence-based policy options

Once aligned, further reflection will be given to the consolidated products to interpret contextualized and evidence-based policy options in order to support Member States in strengthening the coordination/integration of health services delivery in their respective systems. These policy options will inform the tools for change management, adding further from the evidence generated based on the experiences of Member States in implementing initiatives towards more coordinated/integrated services. Priority will be given to ensuring the policy options are relevant to a number of different contexts across the Region and supported by contextualized experiences for easy interpretation (e.g. country vignettes).

PHASE FIVE: REVIEW AND CONSULTATION

Duration: January 2015 – December 2015

Key processes:
5.1 National and sub-national reviews and consultations on draft Framework for Action towards CIHSD
5.2 Advocacy and technical development
5.3 Revisions and finalized Framework for Action towards CIHSD

Output: Validated Framework for Action towards CIHSD through national and sub-national consultations

5.1 National and sub-national reviews and consultations on draft Framework for Action towards CIHSD

Beginning in 2015, the draft Framework for Action towards CIHSD will undergo a series of national and sub-national reviews and consultations with Member States. The consultations will extend beyond that of the forum of Member State focal points to include representation of a diverse number of stakeholders in-country (e.g. private sector, providers, patient and patient forums, researchers etc).

5.2 Advocacy and technical development

During this phase, priority will be given to developing the technical capacity in-country to initiate, scale-up or strengthen the sustainability of initiatives towards the coordination/integration of health services delivery. Policy-makers, researchers, providers, patients and other key stakeholders in the implementation of the Framework for Action towards CIHSD will be engaged in this process to mobilize the commitment needed for this agenda. Efforts for advocacy and technical development may take a number of forms, such as national workshops, round-table discussions for policy dialogue, or international conferences or technical courses. By engaging a number of stakeholders, this process aims to support a cross-cutting, participatory approach to be reflected in national efforts to follow. Ultimately, these processes intend to ensure the necessary leadership is in place within countries to advocate for this work and oversee the unique managerial and technical aspects demanded of more CIHSD.

5.3 Revisions and finalized Framework for Action towards CIHSD

Feedback and comments received during this period of consultation with national and sub-national stakeholders will be taken into consideration during a period of final revisions on the Framework for Action towards CIHSD. Through the advocacy and technical development efforts of this phase, it will be possible to further tailor the policy options and tools for change management to ensure their relevance and applicability to Member States.

PHASE SIX: PREPARATION FOR FINAL APPROVAL

Duration: January 2016 – September 2016

Key processes:
6.1 Formal procedures in preparation for RC66 presentation of the Framework for Action and approval

Output: Final preparation and presentation of the Framework for Action towards CIHSD at RC66

6.1 Formal procedures in preparation for RC66 presentation of the Framework for Action towards CIHSD and approval

The formal procedures in preparation of RC66 in September 2016 will be carried out beginning in January 2016. These processes include the standard review processes for products presented to the Regional Committee, finalization of materials, translations and printing. The finalized Framework for Action towards CIHSD will be presented to Member States for their formal endorsement and commitment to implement the efforts outlined in the identified tools for change management towards more CIHSD.

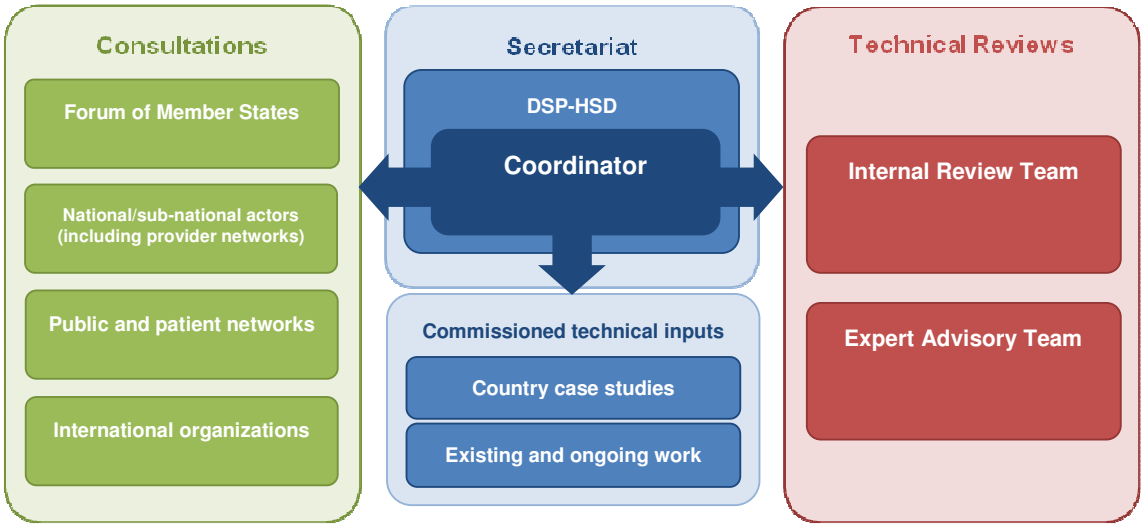
SECTION FIVE: PARTNERSHIPS

5.1 Organization of partnerships in Roadmap processes

The Framework for Action towards CIHSD will be the result of a participative and collective effort. In defining the phases and processes for its development, attention has been given to flag opportunities for strategic partnerships and the engagement of a number of stakeholders from across the Region. This includes partnerships with each technical Division in-house as well as with Member States, external experts, national/sub-national actors, international organizations and the public.

The specific actors envisioned for the processes of review and consultations are defined to follow, with further details developed in the respective annexes noted for each. We note here specifically the Secretariat of this work plan to include the Roadmap Coordinator, staff and consultants of the Health Services Delivery Programme within the Division of Health Systems and Public Health (DSP).

Figure 5.1.1 Organization of partners in processes towards a Framework for Action



5.2 Technical reviews

5.2.1 Internal review team

An internal review team is envisioned as a key partner throughout the phases of the Roadmap, with its composition to include representation from Divisions and Programmes across the Regional Office. The team is intended to enable the clear and transparent communication of this work in-house. The multi-disciplinary membership of the team itself will ensure collaborations in relevant cross-cutting areas on CIHSD can be identified and mobilized accordingly. The team will also serve as an initial peer-review for all technical work related to the Framework for Action, in an effort to ensure outputs are all of high quality and in agreement with the vision and mission of the Regional Office. See Annex 3 for further details.

Box 5.2.1 Functions of the Internal Review Team

- To **participate** in analytical and strategic brainstorming throughout the Roadmap processes;
- To **communicate** this work with respective Divisions and Programmes of work in order to ensure clear lines of communication and transparency;
- To **comment** on draft technical and strategic documents to ensure alignment within the overarching vision of Health 2020 and other lines of activity of WHO and the Regional Office;
- To **mobilize** links across Divisions and Programmes in-house on thematic areas of relevance;
- To **facilitate access** to relevant networks, knowledge and resources and coordinate between parties as needed;
- To **advocate** the components of the Framework for Action towards CIHSD among partners and during country and inter-country work.

5.2.2 Expert Advisory Team

An Expert Advisory Team will be established with its membership to reflect representation from across the Region and from varied areas of technical expertise. This includes experts on integrated care, health services delivery, public health, primary care, secondary care, health systems and change management. The primary function of the Expert Advisory Team will be to provide technical feedback throughout the development of the Framework for Action. The team will also allow a means for further review of the country case study findings as well as the interpretation and analysis of this and other related technical products. See Annex 4 for further details.

Box 5.2.2 Functions of the Expert Advisory Team

- To **provide technical expertise** according to a given area of specialty through participation in discussions and meetings of the Expert Advisory Team;
- To **comment** on all outputs in the development of the Framework for Action towards CIHSD;
- To **facilitate access** to relevant networks, knowledge and resources and coordinate between parties as needed;
- To **validate** the quality and conceptual agreement of technical outputs;
- To **advocate** the components of the Framework for Action towards CIHSD among partners in area of work, ensuring wider dissemination and uptake findings and identified tools for change management.

5.3 Consultations

5.3.1 Member State focal points

A forum of Member State focal points will be established as a formal network for consultation with countries throughout the development of the Framework for Action towards CIHSD. The network is intended to include representation from each of the 53 Member States, with its membership being built through a nomination from each Ministry of Health for a country-specific expert on the delivery of services. The forum of focal points is envisioned as a means to ensure the interests, experiences and needs of Member States are represented and communicated accordingly. The country-specific expertise of the focal points will also be called on in processes related to identifying and developing country case studies as well as in efforts for further consultation and engagement with national and sub-national actors. See Annex 5 for further details.

Box 5.3.1 Function of the forum of Member State Focal Points

- To **represent** the interests, experiences and needs of Member States throughout the processes defined in the development of the Framework for Action towards CIHSD;
- To **provide technical input and country expertise** to all drafted technical and strategic documents of the Framework for Action towards CIHSD;
- To **flag opportunities** for country case studies at the national and sub-national level;
- To **facilitate access** to relevant networks, knowledge and resources in-country and coordinate between parties as needed;
- To **recommend** key stakeholders for in-country consultations and capacity building efforts.

5.3.2 Other partners

National and sub-national actors. A series of national and sub-national consultations are envisioned as key opportunities to engage a broad number of actors, including importantly, health care providers from varied settings of care (e.g. public health services, primary care, secondary care, etc.). This is also to include those in health care leadership and management roles nationally, regionally and locally. Other sectors for consultation may include private organizations, academia and not-for-profits. Formal engagement with these actors is the priority of phase 5, intending to generate discussions as well as the technical capacity and advocacy needed in-country for mobilizing the CIHSD of priority areas.

Public and patient networks. The public's engagement in consultations is a priority to inform the CIHSD from their perspective as citizens and users of the health system. The consultation processes of phase 5 and through earlier engagement with Member States are intended to ensure the public can participate in contextualized, meaningful discussions on their preferences and experiences with the delivery of care.

International partners. International partners in the development of this work will include importantly, the International Foundation for Integrated Care – a network of organizations and professionals for the exchange of knowledge and experiences on integrated care, as well as the European Commission and the European Observatory on Health Systems and Policies. The engagement and opportunity to consult with a diverse number of international partners will be further explored during the kick-off phase of this work.

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